



SALARY REDUCTION AGREEMENT
STATE OF WASHINGTON
DEPARTMENT OF RETIREMENT SYSTEMS

P.O. Box 40931 • Olympia, WA 98504-0931 • www.drs.wa.gov

For questions, please call DCAP
customer service at 360-664-7005
(in the Olympia area) or toll-free at
1-800-423-1524 and select option 4.

Please type or print in dark ink. Return completed form to DRS.

Please check the appropriate box(es) for all changes:

☐ OPEN ENROLLMENT ☐ NEW EMPLOYEE ☐ STATUS CHANGE/EFFECTIVE DATE _____

Change in family status (May require additional information)

- | | | |
|---|--|---|
| <input type="checkbox"/> 1. MARRIAGE | <input type="checkbox"/> 5. TERMINATION OF EMPLOYMENT OF SPOUSE | <input type="checkbox"/> 9. CHANGE IN DEPENDENT CARE/PROVIDER COSTS |
| <input type="checkbox"/> 2. DIVORCE OR LEGAL SEPARATION | <input type="checkbox"/> 6. EMPLOYMENT OF UNEMPLOYED SPOUSE | <input type="checkbox"/> 10. NO LONGER USE DEPENDENT CARE SERVICES |
| <input type="checkbox"/> 3. DEATH OF SPOUSE/DEPENDENT | <input type="checkbox"/> 7. SUBSTANTIAL CHANGE IN EMPLOYMENT HOURS | <input type="checkbox"/> 11. TERMINATION FROM STATE SERVICE |
| <input type="checkbox"/> 4. ADDITION OF DEPENDENT | <input type="checkbox"/> 8. CHANGE IN PROVIDER | |

Section One: Personal Information

1. Name _____ 2. SSN _____
☐ Change Last First M.I.

3. Address _____ 4. Work Phone _____
☐ Change Number Street

City State Zip 5. Home Phone _____

6. Current Employer _____

E-mail Address _____

Married Yes ☐ No ☐

7. List qualifying dependents below:

| Last | First | M.I. | Date of Birth |
|------|-------|------|---------------|
| | | | |
| | | | |
| | | | |
| | | | |

8. If higher education employee, circle the number of months paid: 9 10 11 12 Not Applicable

| | | | |
|-------------------------------|---------------------------------------|------------------------------------|--|
| 9. Annual Earned Income \$ | 10. Spouse Annual Earned Income \$ | 11. Per Pay Period Reduction \$ | 12. Total Annual Reduction <u>20</u> \$ |
|-------------------------------|---------------------------------------|------------------------------------|--|

Section Two: Authorization

I authorize payroll to deduct the amount set forth in Section One, Box 12 for the plan year and to transmit this amount in equal installments to the Department of Retirement Systems for the Dependent Care Assistance Salary Reduction Program. This agreement supersedes any prior agreement and will continue until further notification as set forth in the Plan. I acknowledge I have read and understand all sections of the "DCAP Memo of Understanding" on the reverse side of this agreement.

X _____
Signature of Employee Date

Section Three: FOR DCAP USE ONLY

| | | |
|--------------------|-----------------------------|---------------------------------------|
| 1. AGENCY NUMBER | 2. SUB. AGENCY NUMBER | 3. PAY PERIODS REMAINING IN PLAN YEAR |
| 4. EFFECTIVE MONTH | 5. REDUCTION BEGINNING DATE | 6. REDUCTION PER PAY PERIOD |



DCAP MEMO OF UNDERSTANDING

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THIS MEMO ONLY HIGHLIGHTS THE EMPLOYEES' DEPENDENT CARE ASSISTANCE SALARY REDUCTION PROGRAM. YOU SHOULD REFER TO A COPY OF THE PROGRAM REGULATIONS FOR SPECIFIC DETAILS.

I UNDERSTAND the following:

1. Enrollment is required for each plan (calendar) year (WAC 415-600-110 and WAC 415-600-210).
2. My gross salary will be reduced each regular pay period by an equal fraction of the total salary reduction amount that I have elected (WAC 415-600-280). This amount should not exceed my earned income and should not exceed the earned income of my spouse (WAC 415-600-250 and WAC 415-600-260).
3. I may not change or terminate my election during the plan year except in the case of a "qualifying change in status" (WAC 415-600-240).
4. My dependent care account will be used to reimburse only eligible dependent care expenses for services incurred during the plan year (WAC 415-600-110 and 415-600-310).
5. Services must occur on days I work and if married, on days my spouse works; or if my spouse is a full-time student, services must occur on days my spouse attends school (WAC 415-600-310).
6. Only expenses directly related to the care or supervision of qualifying person(s) may be claimed for reimbursement (WAC 415-600-110 and 415-600-310).
7. Qualifying person(s) must be under 13 years of age, or physically and/or mentally incapable of self-care and spend at least 8 hours each day in my household (WAC 415-600-110 and 415-600-310).
8. If my provider is a child of mine, she/he must not be an IRS dependent and must be at least age 19 as of the close of the plan year (WAC 415-600-310).
9. Any amounts remaining in my dependent care account after March 31 of the following year will be forfeited to the State of Washington (WAC 415-600-020 and 415-600-440).
10. Funds in my dependent care account belong to the State of Washington until paid to me under the terms of the Program. I realize that I may not assign or transfer my rights in the Program (WAC 415-600-610).
11. As a result of reducing my gross income, my social security benefit may be lower (WAC 415-600-020).
12. The program may reduce my salary reduction amount at any time to assure that the Dependent Care Assistance Program satisfies existing or future anti-discrimination requirements of the Internal Revenue Code (WAC 415-600-270).
13. The State of Washington retains control over all aspects of the Program including the right to amend or terminate the Program (WAC 415-600-290).
14. Neither the Department nor the State of Washington makes any commitment or guarantee that any amount paid to or for the benefit of a participant will be excludable from the participant's gross income for federal or state income tax purposes (WAC 415-600-630).

I ACKNOWLEDGE THAT I HAVE RECEIVED AND REVIEWED A COPY OF THE DEPENDENT CARE ASSISTANCE PROGRAM REGULATIONS. I FURTHER ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL SECTIONS OF THE "DCAP MEMO OF UNDERSTANDING."